**PROVIDENT LIFE and ACCIDENT INSURANCE COMPANY (Provident)**
1 Fountain Square
Chattanooga, TN 37402

# APPLICATION FOR ACCIDENT INSURANCE

**Applying For:**
New Coverage ☐
Change of Coverage ☐

## Section A: EMPLOYEE - Applicant Information (Always complete)

| 1. Name (First) (Middle) (Last) | | | | 2. Social Security No. |
|---|---|---|---|---|
| 3. Residence Address (Street / Box No.) (City) (State) (Zip) | | | | |
| 4. (a) Birthdate | 4. (b) State of Birth | 5. Age | 6. Sex ☐ F ☐ M | 7. Home Phone Number |
| 8. Employer's Name | 9. Employment Date | 10. Are you actively at work? ☐ Yes ☐ No | | 11. Payroll No. |
| 12. Occupation | 13. Scheduled Number of Work Hours per Week | | | 14. Monthly Salary $ |
| 15. a. Primary Beneficiary _____ b. Relationship _____ | | 16. a. Contingent Beneficiary _____ b. Relationship _____ | | |

## Section B: DEPENDENT INFORMATION (Complete if applying for Spouse or Child Individual Plan or if applying for Spouse coverage under Multi-Life Plan)

| 17. Name (First) (Middle) (Last) | | | | |
|---|---|---|---|---|
| 18. (a) Birthdate | 18. (b) State of Birth | 19. Age | 20. Sex ☐ F ☐ M | 21. Relationship |
| 22. Is Spouse/Child actively at work? ☐ Yes ☐ No | | 23. Hours Worked per Week | 24. Occupation | |

Complete Question 25 only if answered Question 22 " no".

25. Is Spouse/Child currently Disabled or unable to work? ..... ☐ Yes ☐ No

| 26 a. Primary Beneficiary _____ b. Relationship _____ | 27 a. Contingent Beneficiary _____ b. Relationship _____ |
|---|---|

## Section C: POLICY INFORMATION (Continued on next page)

Coverage Plans (select either an Individual or Multi-Life Plan):

28a. Individual Plan
(Separate application required for each insured)
☐ Employee ☐ Spouse ☐ Child

**or**

28b. Multi-Life Plan
☐ Employee / Spouse ☐ One Parent Family: Employee
☐ Two Parent Family ☐ One Parent Family: Spouse

29. Plan of Insurance applying for:
☐ On and Off-Job Accident Coverage
☐ Off-Job Accident Coverage
☐ Reduced On & Off-Job Accident Coverage

30. **Base Policy Premium $**

31. Will coverage applied for replace or modify any Accident or Disability insurance coverage? If " yes", provide details below and complete and submit required replacement forms if needed. ..... ☐ Yes ☐ No

| Insured's Name | Company Name | Policy Number |
|---|---|---|
| | | |

Employee Name: (Applicant) _____ Employee SSN: (Applicant) _____

## Section C: POLICY INFORMATION

| 32. **Rider Coverage and Premiums** | Employee Premium | Spouse Premium | Total Premium |
|---|---|---|---|
| Disability Income Rider<br>**or** ☐ Accident (Off-Job) (Section D not required)<br>☐ Accident (Off-Job) / Sickness (Complete Section D)<br>Employee Monthly Benefit $ _____<br>Spouse Monthly Benefit $ _____<br>Benefit Period _____ months<br>Elimination Period for Accident _____ days<br>Elimination Period for Sickness _____ days | $ | $ | $ |
| ☐ Sickness Hospital Confinement Rider (Complete Section D) | | | $ |
| ☐ Other | | | $ |
| ☐ Other | | | $ |
| 33. **Total Premium for Riders** | | | $ |

34. **Total Premium for Base Policy and Riders (Provide sum for # 30 and # 33)**

Base Policy Premium $ _____

Total Premium for Riders $ _____

Total $ _____

35. **Payroll Premium Deducted:**

☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Other _____

**POLICY EFFECTIVE DATE** _____ **TOTAL PAYROLL PREMIUM $** _____

## Section D: UNDERWRITING (Complete as required for all underwritten coverage) (Continued on next page)

| | | Employee (Applicant) | Spouse |
|---|---|---|---|
| Accident / Sickness Disability and Sickness Hospital Confinement Rider | 36. Have you or any person applying for coverage tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or received medical advice or sought treatment for Acquired Immune Deficiency Syndrome (AIDS) or AIDS- related complex (ARC)? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | 37. Within the past 12 months, have you or any person applying for coverage received medical advice or sought treatment for insulin-dependent diabetes, any disease or abnormality of the heart, heart attack, stroke or liver disease including chronic hepatitis or been treated with 3 or more medications for high blood pressure? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | 38. List current Height and Weight | Height _____<br>Weight _____ | Height _____<br>Weight _____ |
| Sickness Hospital Confinement Rider (Complete Questions 36-39) | 39. Within the past 12 months, have you or any person applying for coverage received medical advice or sought treatment for cancer of any type including leukemia, Hodgkin's disease, melanoma (other than basal cell or squamous cell carcinoma), malignant tumors of any kind or kidney disease (other than kidney stones)? | ☐ Yes ☐ No | ☐ Yes ☐ No |

Employee Name: (Applicant) _____ Employee SSN: (Applicant) _____

**Section D: UNDERWRITING (Complete as required for all underwritten coverage)**

| | | Employee (Applicant) | Spouse |
|---|---|---|---|
| Accident / Sickness Disability Rider (Complete Questions 36-38, 40-42) | 40. Within the past 12 months, have you or any person applying for coverage received medical advice or sought treatment for any back, knee, neck, shoulder or joint disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | 41. Within the past 12 months, have you or any person applying for coverage been unable to perform normal duties of your occupation due to an injury or illness, other than normal pregnancy, for more than 10 consecutive days? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | 42. Do you have any group or individual disability insurance pending or in force that will not be replaced or modified? If "yes", give details. | ☐ Yes ☐ No | N/A |

| Name of Company | Monthly Benefit | Elimination/Benefit Period |
|---|---|---|
| | | |

43. Have you received an Outline of Coverage form? ..... ☐ Yes ☐ No

**Employee (Applicant) Statement**

I understand that coverage issued is based on all statements and answers recorded above. I agree that any child proposed for dependent coverage must be unmarried and under age 25 to be covered for benefits. These statements and answers are complete and true. I understand that as the undersigned, I am the owner of any coverage issued under this application.

I understand that the Policy Effective Date of any insurance policy issued under Provident's rules, limits or standards is shown above on the application. The Policy Effective Date will be no earlier than the application signed date and no later than the date payroll deductions begin or premium is collected for non-payroll deducted policies.

I authorize my employer to deduct the premiums for this insurance from my earnings (unless I have completed additional forms for a non-payroll method).

Dated _____ (Month/Day/Year) at _____ (City, State)

☐ If this box is checked, a PIN# secured enrollment has authorized the application and a signature is not required.

Employee (Applicant) Signature

**Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is guilty of insurance fraud.**

**Agent Statements:** (1) Do you have knowledge or reason to believe that the proposed insurance is intended to replace any existing insurance? ☐ Yes ☐ No (2) To the best of your knowledge and belief, the above statements and answers are complete and true.

Dated _____ (Month/Day/Year)

Licensed Agent's Signature

Agent's License No. _____ Print Name of Agent _____

**Policy Number** _____

Employee Name: _____ Employee SSN: _____
(Applicant) (Applicant)

**INSTRUCTIONS**

**Complete the information below only if you or any person proposed for coverage on the preceding application is currently eligible for Medicare. To be eligible for Medicare, you must be either: (1) age 65 or older; or (2) disabled.**

## Medicare Certification Form

This is to certify that I have received the "Guide to Health Insurance for People with Medicare" and the "Important Notice to Persons on Medicare".

_____ _____
Date Signature of Applicant